Summary of Proposed Rules for Non-profit Hospitals' Financial Assistance, Billing and Collection Practices

Today, many Americans are losing the battle between physical health and financial security. Currently, one in five U.S. families reported difficulty paying a medical bill in 2011, with one in ten reported they or a family member were currently responsible for a medical bill they could not pay at all.[i] Medical debt strikes families with insurance, too, though low-income, Hispanic and black families and families with children and adults under the age of 65 have been hit particularly hard.[ii] While many factors contribute to medical debt, aggressive collection efforts used by hospitals and third-party contractors have been flagged by the press, policymakers, and advocates as a crucial part of the problem. But the Affordable Care Act (ACA) includes new requirements for non-profit hospitals that will better protect low- and middle-income families from medical debt. The law now requires these hospitals to:

- Have a well-publicized, clear financial assistance policy available to patients and the public
- Use reasonable efforts to determine whether patients qualify for financial help before engaging in aggressive collection tactics currently used by some hospitals and their agents
- Stop overcharging people who qualify for financial help

Although these basic standards have been in effect since 2010, advocates have been asking the Internal Revenue Service (IRS) and Treasury Department to issue more detailed rules that would truly define the scope of protections patients can expect regarding their hospital bills. In June, the IRS and Treasury Department issued a Notice of Proposed Rulemaking in the Federal Register and are seeking public comments. This brief summarizes key points from the IRS Proposed Rules.

Quick Facts

- These ACA requirements have to do with hospitals' federal tax status, which gives the IRS and Treasury Department jurisdiction. They do not apply to for-profit hospitals.
- The agencies are requesting two sets of comments. The first set—on whether the proposed rules comply with the Paperwork Reduction Act—are due August 27, 2012 to the Office of Management and Budget. The second set—dealing with the substance of the Proposed Rules—are due to the IRS on September 24, 2012.
- These rules will apply to all non-profit hospitals with 501(c)(3) status, including public hospitals that may be exempt from filing federal tax returns.

Financial Assistance and Emergency Medical Care Policies

The ACA requires non-profit hospitals to have a written financial assistance policy that clearly spells out what kind of help is available, who is eligible, and how to apply. And, non-profit hospitals must make sure the policy is widely publicized in the communities they serve. The Proposed Rules further specify what hospitals must do to meet these standards.

Under the Proposed Rules:

- Non-profit hospitals must **establish a written financial assistance policy (FAP), billing and collections policy, and emergency medical care policy**. These policies must be in writing,

adopted by hospital leadership (governing board, board committee, authorized manager, etc.), and implemented (defined as "consistently carried out") in order to be considered "established."

- To fulfill the ACA's requirement that non-profits **widely publicize their policies**, the FAP must explain how members of the public can readily obtain it. At a minimum, these hospitals must:
    - Provide free hard copies of the full FAP, FAP application form, and plain language summary upon request, by mail and in public locations within the hospital.
    - Make the FAP and plain language summary available online.
    - Inform and notify visitors and members of the public through a "conspicuous display" in a "manner reasonably calculated" to reach community members most likely to need financial assistance.
- FAP documents must be available in English and the primary language of any Limited English Proficiency populations making up more than 10 percent of residents in the community served.
- The FAP must disclose all discounts and charity care, eligibility criteria, and the amount to which any discount would be applied (such as gross charges) for each level of help.
- The **emergency medical care policy** (separate from the FAP) must state that the hospital provides emergency care regardless of whether an individual qualifies for FAP. The policy must state that debt collection activity in the ER or other areas of the hospital where emergency medical conditions are treated is prohibited. Demanding upfront payment in the ER is listed as an example of prohibited behavior.

Debt Collection

The ACA requires non-profit hospitals to make "reasonable efforts" to determine whether a patient qualifies for financial help under its policy before engaging in "extraordinary collection actions." The Proposed Rules define these two key terms. They also establish a minimum timeline and process non-profit hospitals and third parties must follow when attempting to collect patient bills—important safeguards for patients that do not currently exist in all 50 states.

Under the Proposed Rules:

- **Extraordinary collection actions** (ECAs) are defined as anything that requires a legal or judicial process (including wage garnishment, liens, lawsuits, etc.); reporting adverse information to credit bureaus; and selling a debt.
- **Reasonable effort** is defined as notifying the patient about FAP; providing patients who submit incomplete FAP applications with the information they need to complete it; and making and documenting a determination of eligibility when a complete application is received. **Notifying a patient about FAP** is further defined as:
    - Giving patients a plain language summary of the FAP and offering an FAP application form prior to discharge
    - Including a plain language summary with all (and at least 3) billing statements and written communications about the bill during the notification period
    - Informing patients about FAP in all oral communications about their bill during the notification period
    - Providing at least one written notice 30 days before the end of the notification period that describes ECAs the hospital or authorized third party may take if an FAP application or payment is not received by the end of the notification period.
- Rather than prohibit ECAs altogether, the Proposed Rules outline a **defined timeline and minimum set of safeguards hospitals must observe** as part of the requirement that they make a "reasonable effort" to qualify patients for FAP.

- In general, hospitals are barred from engaging in extraordinary collection actions from the date of service to 120 days after they provide the patient with the first bill. The proposed rules refer to this as the **notification period** because hospitals must meet certain notification requirements (see Table 2) during this time.
- Once this time period lapses, hospitals can use extraordinary collection actions. But patients have some protections up to 240 days after the first bill: if they submit even an incomplete FA application, the hospital must suspend its collection activity and inform the patient about what's missing from their application. The proposed rules refer to this as the **application period.**
- So long as the patient submits a completed application within the time frame specified in the regulations (from the date of service up to 240 days after the hospital provides the first bill), the hospital must make a determination of eligibility, notify the patient, and document the determination in a timely way.
- If a patient is found eligible for FAP, hospitals must refund any excess payments and take steps to reverse any negative impacts from extraordinary collection actions.
- **Most of these requirements apply to third parties the hospital engages to help with billing and collections.**

Limiting Charges

The ACA prohibits nonprofit hospitals from using "gross charges," known colloquially as the rack rate or chargemaster rate. Gross charges are often a starting point in providers' negotiations with other payers, such as private insurers, Medicare, and state Medicaid programs. They are usually set much higher than the costs a hospital incurs for providing care. One unintended consequence of this system is that uninsured and underinsured patients can be held liable for significantly more money than insured patients, Medicare or commercial insurance plans. To set this right, the ACA now requires non-profit hospitals to limit charges to patients who qualify for financial assistance to the "amounts generally billed" to insured patients.

Under the Proposed Rules**:**

- The IRS and Treasury take a narrower view of the prohibition on gross charges, limiting it so that it only protects patients who qualify for financial assistance.
- Patients who are eligible for financial assistance must be charged less than gross charges for *any* care they receive, and no more than the amount generally billed (AGB) to insured patients for *emergency or medically necessary care.*
- Hospitals can use one of two methods to determine AGB:
  - A **look-back method** that is based on actual claims paid by Medicare fee-for-service and Medicare beneficiaries, or by Medicare fee-for-service plus all private health insurers (including Medicare Advantage) and their beneficiaries
  - A **prospective method** that is based on a hospital's estimate of what Medicare and a Medicare beneficiary would pay for a particular service.
- Hospitals that meet the "reasonable effort" standard (see Debt Collection, above) are granted safe harbor if they send a bill that lists gross charges before they have received a patient's full application for financial assistance.

[i] Robin A. Cohen, Renee M. Gindi, Whitney K. Kirzinger. *Financial Burden of Medical Care: Early Release of Estimates from the National Health Interview Survey, January-June 2011*. Division of Health Interview Statistics, National Center for Health Statistics, Centers for Disease Control and Prevention, March 2012.
[ii] *Id.*